		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020297

Facility Name: MANORCARE AT ROLLING MEADOWS

Address: 425 Kirchoff Rd (Number) Rolling Meadows (City) 60008 (Zip Code)

County: Cook

Telephone Number: (847) 397-2400 **Fax #** (847) 397-2414

IDPA ID Number: 521077856001

Date of Initial License for Current Owners: 07/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/01 to 05/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,573	1,935	7,312	14,820	8
9	SNF/PED					9
10	ICF	22,295	10,345	1,023	33,663	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,868	12,280	8,335	48,483	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.70%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 6,707

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/02 Fiscal Year: 5/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	311,556	31,357	2,261	345,174	1,902	347,076		347,076			1
2	Food Purchase		229,051		229,051		229,051	(2,400)	226,651			2
3	Housekeeping	153,463	17,567	2,967	173,997		173,997		173,997			3
4	Laundry	50,663	22,567		73,230		73,230		73,230			4
5	Heat and Other Utilities			169,535	169,535	9,044	178,579		178,579			5
6	Maintenance	42,148	17,174	45,071	104,393		104,393		104,393			6
7	Other (specify):*			1,601	1,601		1,601		1,601			7
8	**TOTAL General Services**	557,830	317,716	221,435	1,096,981	10,946	1,107,927	(2,400)	1,105,527			8
	B. Health Care and Programs											
9	Medical Director			21,375	21,375		21,375		21,375			9
10	Nursing and Medical Records	2,425,096	162,656	21,894	2,609,646	42,073	2,651,719		2,651,719			10
10a	Therapy	225,179	1,014	27,007	253,200		253,200		253,200			10a
11	Activities	116,142	1,919	2,294	120,355		120,355		120,355			11
12	Social Services	53,715	243	(1,352)	52,606		52,606		52,606			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,820,132	165,832	71,218	3,057,182	42,073	3,099,255		3,099,255			16
	C. General Administration											
17	Administrative	80,272		368,619	448,891	(121,543)	327,348		327,348			17
18	Directors Fees											18
19	Professional Services			11,571	11,571	(11,571)						19
20	Dues, Fees, Subscriptions & Promotions			98,189	98,189		98,189	(24,447)	73,742			20
21	Clerical & General Office Expenses	271,845	50,357	289,142	611,344	11,571	622,915	(255,284)	367,631			21
22	Employee Benefits & Payroll Taxes			641,249	641,249	13,995	655,244		655,244			22
23	Inservice Training & Education			2,809	2,809		2,809		2,809			23
24	Travel and Seminar			9,329	9,329		9,329		9,329			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			110,367	110,367		110,367		110,367			26
27	Other (specify):*			985	985		985		985			27
28	**TOTAL General Administration**	352,117	50,357	1,532,260	1,934,734	(107,548)	1,827,186	(279,731)	1,547,455			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,730,079	533,905	1,824,913	6,088,897	(54,529)	6,034,368	(282,131)	5,752,237			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS #0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			289,861	289,861	48,518	338,379		338,379			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					6,011	6,011	(16,599)	(10,588)			32
33	Real Estate Taxes			387,282	387,282		387,282	1,823	389,105			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,244	20,244		20,244		20,244			35
36	Other (specify):*											36
37	**TOTAL Ownership**			697,387	697,387	54,529	751,916	(14,776)	737,140			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		169,903	17,495	187,398		187,398		187,398			39
40	Barber and Beauty Shops			24,835	24,835		24,835		24,835			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,864	84,864		84,864		84,864			42
43	Other (specify):*		29,600		29,600		29,600		29,600			43
44	**TOTAL Special Cost Centers**		199,503	127,194	326,697		326,697		326,697			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,730,079	733,408	2,649,494	7,112,981		7,112,981	(296,907)	6,816,074			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,400)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(16,599)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,099)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,097)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(135)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(249,953)	21		24
25	Fund Raising, Advertising and Promotional	(24,447)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	1,823	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (296,907)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (296,907)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

MANORCARE AT ROLLING MEADOWS

ID# 0020297

Report Period Beginning: 06/01/01

Ending: 05/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(24,447)	0	0	0	0	0	0	0	0	0	0	(24,447)	20
21	Clerical & General Office Expenses	(255,284)	0	0	0	0	0	0	0	0	0	0	(255,284)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(279,731)	0	0	0	0	0	0	0	0	0	0	(279,731)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(282,131)	0	0	0	0	0	0	0	0	0	0	(282,131)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,599)	0	0	0	0	0	0	0	0	0	0	(16,599)	32
33	Real Estate Taxes	1,823	0	0	0	0	0	0	0	0	0	0	1,823	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(14,776)	0	0	0	0	0	0	0	0	0	0	(14,776)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(296,907)	0	0	0	0	0	0	0	0	0	0	(296,907)	45

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Page 8	Home Office Allocation	$ 368,619	HCR ManorCare, Inc.	100.00%	$ 368,619	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V		10a	Therapy Management	15,000	Heartland Management Services	100.00%	15,000		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 383,619			$ 383,619	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	$	$	6,776,713	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	680,609	406,990	6,776,713	1,902	2
3	5	Utilities - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	154,435		6,776,713	516	3
4	5	Utilities - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	3,051,710		6,776,713	8,528	4
5	10	Nursing - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	10,993,908	7,606,940	6,776,713	36,758	5
6	10	Nursing - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	1,902,166	1,264,589	6,776,713	5,315	6
7	17	General & Admin - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	14,112,784	11,038,075	6,776,713	47,186	7
8	17	General & Admin - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	71,533,109	46,622,737	6,776,713	199,889	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	2,156,484		6,776,713	7,210	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	2,428,174		6,776,713	6,785	10
11	30	Depreciation - Direct	Accumulated Cost	2,026,840,883	357 Nurs. Fac.	101,489		6,776,713	339	11
12	30	Depreciation - Pooled	Accumulated Cost	2,425,139,746	357 Nurs. Fac.	17,241,472		6,776,713	48,179	12
13										13
14	32	Interest				12,439,256			6,011	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 136,795,596	$ 66,939,331		$ 368,618	25

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5								Home Office Interest			6,011	5
	Working Capital											
6												6
7												7
8								Interest Income			(16,599)	8
9	TOTAL Facility Related						$	$			$ (10,588)	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ (10,588)	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS **#** 0020297 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	385,459	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	387,282	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,823	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	387,282	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	389,104	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	318,892	8
	1998	375,895	9
	1999	334,836	10
	2000	385,459	11
	2001	387,282	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MANORCARE AT ROLLING MEADOWS COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0020297

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-26-400-025-0000	See Attached	$ 345,445.83	$ 345,445.83
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 345,445.83	$ 345,445.83

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,523 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1977	$ 155,000	1
2					2
3	TOTALS			$ 155,000	3

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155			1977	$ 1,350,315	$ 53,925		$ 53,925	$	$ 1,075,047	4
5				1990	765,804						5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)										9
10				1987	72,739	168,837		168,837		1,103,545	10
11				1988	33,303						11
12				1989	74,517						12
13				1990	157,389						13
14				1991	127,927						14
15				1992	107,998						15
16				1993	73,889						16
17				1994	71,280						17
18				1995	236,489						18
19	HVAC/DUCTWORK			1996	3,845						19
20	PLUMBING			1996	2,184						20
21	CORPORATE OVERHEAD-ARCADIA/DINING			1996	7,272						21
22	REMODEL ARCADIA/DINING/BEDROOM			1996	95,560						22
23	PROFESSIONAL FEES-ARCADIA/DINING			1996	1,737						23
24	CORNER GUARDS			1996	1,340						24
25	WOODEN DOORS			1996	11,077						25
26	WALLCOVERINGS			1996	5,279						26
27	ELECTRICAL/LIGHTING			1996	7,005						27
28	CARPETING			1996	3,300						28
29	REBUILD GENERATOR			1996	1,927						29
30	REPLACE SMOKE DETECTOR			1996	2,156						30
31	INSTALL HANDRAILS			1997	8,660						31
32	WALL GUARDS			1997	2,756						32
33	REPLACE CEILING TILES			1997	12,173						33
34	REMOVE & INSTALL FIRE DOORS			1997	2,012						34
35	INSTALL CLOSET DOORS			1997	10,821						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WALLCOVERINGS	1997	$ 4,812	$		$	$	$	37
38	DECORATING	1997	10,594						38
39	CARPETING	1997	2,343						39
40	FLOORING	1997	11,254						40
41	REPAIR ELEVATOR	1997	3,430						41
42	ROOFING	1997	1,679						42
43	REMODELING-ARCADIA	1997	8,663						43
44	CONNECT WATER AND GAS LINES	1997	1,705						44
45	CORPORATE OVERHEAD-ARCADIA/DINING	1997	10,515						45
46	RETIREMENTS	1987	(44,531)						46
47	RETIREMENTS	1992	(36,743)						47
48	FACILITY PLAN ALLOC,-ARCADIA/DINING	1997	5,964						48
49	REPLACE CLOSET DOORS	1997	12,000						49
50	PROFESSIONAL FEES-ARCADIA/DINING	1997	1,396						50
51	CEILING TILES	1997	10,349						51
52	INSTALL CIRCULATING PUMPS	1997	2,250						52
53	BOILER WORK	1997	5,613						53
54	WALLPAPER	1997	482						54
55	STORAGE SHED	1997	789						55
56	ROOF WORK	1998	53,389						56
57	DOORS/WINDOWS	1998	10,090						57
58	PLUMBING	1998	3,838						58
59	RENOVATE PT & OT ROOMS	1998	4,500						59
60	DOOR & WINDOW CASINGS	1998	4,500						60
61	GENERAL CONTRACTOR FEES-PT & OT ROOMS	1998	4,416						61
62	INSTALL STEEL DOORS	1998	4,224						62
63	ELECTRICAL	1998	754						63
64	REMODELING	1997	(8,489)						64
65	PAINTING/WALLCOVERING	1998	36,239						65
66	PLUMBING	1998	13,534						66
67	ELECTRICAL	1998	10,004						67
68	DEVELOPERS-PT & OT ROOMS	1998	11,097						68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,411,414	$ 222,762		$ 222,762	$	$ 2,178,592	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,411,414	$ 222,762		$ 222,762	$	$ 2,178,592	1
2	FLOORING/CEILING	1998	985						2
3	HVAC	1998	37,124						3
4	DOOR/WINDOW	1998	8,160						4
5	SIGN	1998	11,862						5
6	ROOFING	1998	92,520						6
7	MASONARY	1998	1,499						7
8	CARPENTRY	1998	1,475						8
9	FINISH STUDS	1998	26,279						9
10	GENERAL CONTRACTOR FEES-PT & OT ROOMS	1998	4,601						10
11	CONCRETE SIDEWALK	1998	1,482						11
12	FLOORING/CEILING	1999	1,340						12
13	CARPENTRY	1999	19,278						13
14	FINISH STUDS	1999	25,000						14
15	PAINTING/WALLCOVERING	1999	750						15
16	WINDOW TREATMENTS	1999	525						16
17	ROOF WORK	1999	6,098						17
18	ROOFING CONTRACT	1999	876						18
19	DRAIN/FLASH SCUPPERS/OVERFLOW	1999	1,782						19
20	ROOFING CONTRACT	1999	6,098						20
21	BUILDING IMPROVEMENTS-NURSES STATIONS	1999	4,554						21
22	BUILDING IMPROVEMENTS-NURSES STATIONS	1999	22,150						22
23	INSTALL CLOSETS	1999	2,895						23
24	25 EXIT SIGNS FOR BU	1999	4,810						24
25	VINYL WALLCOVERING	1999	336						25
26	WALLCOVERING	1999	226						26
27	RENOVATE NURSING STATIONS	1999	11,478						27
28	WALLCOVERING	1999	2,245						28
29	DAMPER MOTOR	1999	2,693						29
30	CHART RACK	2000	1,450						30
31	ELECTRICAL FOR A/C UNITS	2000	1,214						31
32		2000	294						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,713,493	$ 222,762		$ 222,762	$	$ 2,178,592	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,713,493	$ 222,762		$ 222,762	$	$ 2,178,592	1
2	ELECTRICAL FOR A/C UNITS	2000	1,151						2
3	WORK STATIONS BOOKKEEPING & PAYROLL	2000	5,975						3
4	WORK STATIONS	2000	728						4
5	EXTERIOR LIGHTING	2000	19,956						5
6	CEILING TILE, PAINTING, CARPET	2000	900						6
7	FENCING	2000	17,820						7
8	FENCING	2000	1,980						8
9	CONCRETE, MASONRY, CARPENTRY	2000	49,335						9
10	CARPET	2000	35,925						10
11	WALLCOVERING	2000	52,636						11
12	ELECTRICAL	2000	34,947						12
13	INTEREST - CONST & GENERAL O/H ARCADIA	2000	74,862						13
14	ARCADIA RENOVATION	2000	12,075						14
15	ARCADIA RENO - DRAPES	2001	2,843						15
16	ARCADIA RENO - CARPENTRY	2001	6,748						16
17	ARCADIA RENO-CONTRACTOR	2001	50,636						17
18	ARCADIA RENO - ELECTRICAL	2001	3,560						18
19	BORDER	2001	170						19
20	KITCHEN WALLS AND FLOOR	2002	2,566						20
21	KITCHEN WALLS AND FLOOR	2002	14,796						21
22	DOORS	2002	6,445						22
23	DOORS	2002	1,868						23
24	DOORS	2002	7,740						24
25	PAINTING	2002	204						25
26	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1995	(791)	(79)		(79)		(554)	26
27	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1996	(7,272)	(727)		(727)		(4,363)	27
28	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1997	(10,515)	(1,051)		(1,051)		(5,432)	28
29	C/R 5/31/99 AUDIT ADJ. - FACILITY PLAN ALLOC	1997	(5,964)	(596)		(596)		(2,982)	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,094,817	$ 220,309		$ 220,309	$	$ 2,165,261	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 898,398	$ 69,553	$ 69,553	$		$ 651,716	71
72	Current Year Purchases	73,050						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			48,518	48,518			74
75	TOTALS	$ 971,449	$ 69,553	$ 118,071	$ 48,518		$ 651,716	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,221,266	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 289,862	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 338,380	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 48,518	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,816,978	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 20,244 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	3896	hrs	$ 95,487	231	$ 5,775	$ 548	4,127	$ 101,810	1
2	Licensed Speech and Language Development Therapist	10a	528	hrs	12,931	99	2,486	39	627	15,456	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	4764	hrs	116,761	750	18,746	427	5,514	135,934	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				169,903		169,903	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): X-Ray, Lab	10a,39 Col 3					17,495			17,495	13
14	TOTAL				$ 225,179	1,080	$ 44,502	$ 170,917	10,268	$ 440,598	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 13,104	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (313,755))	1,296,652		3
4	Supply Inventory (priced at)	8,886		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,926		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,327,568	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	155,000		13
14	Buildings, at Historical Cost	4,094,817		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	971,449		16
17	Accumulated Depreciation (book methods)	(2,816,978)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,404,288	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,731,856	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 26,586	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	372,514		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	387,282		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	41,203		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 827,585	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	9,672		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 9,672	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 837,257	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,894,599	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,731,856	$	48

***(See instructions.)**

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,277,494	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,277,494	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	267,079	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 267,079	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(649,974)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (649,974)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,894,599	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,150,583	1
2	Discounts and Allowances for all Levels	(664,326)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,486,257	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	658,368	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 658,368	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,401	12
13	Barber and Beauty Care	25,152	13
14	Non-Patient Meals	1,035	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	162,080	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,964	19
20	Radiology and X-Ray	39	20
21	Other Medical Services	1,050	21
22	Laundry	3,115	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 218,836	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,540	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,540	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	2,059	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,059	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,380,060	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,096,981	31
32	Health Care	3,057,182	32
33	General Administration	1,934,734	33
	B. Capital Expense		
34	Ownership	697,387	34
	C. Ancillary Expense		
35	Special Cost Centers	326,697	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,112,981	40
41	**Income before Income Taxes (line 30 minus line 40)****	267,079	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 267,079	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,829	1,984	$ 54,534	$ 27.49	1
2	Assistant Director of Nursing	1,026	1,113	27,252	24.49	2
3	Registered Nurses	27,348	29,669	661,507	22.30	3
4	Licensed Practical Nurses	20,503	22,243	418,610	18.82	4
5	Nurse Aides & Orderlies	101,370	109,974	1,239,671	11.27	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	8,571	9,186	225,179	24.51	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,718	10,542	116,142	11.02	10
11	Social Service Workers	3,058	3,318	53,715	16.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,715	32,334	311,556	9.64	15
16	Dishwashers					16
17	Maintenance Workers	2,706	2,936	42,148	14.36	17
18	Housekeepers	16,043	17,406	153,463	8.82	18
19	Laundry	5,731	6,214	50,663	8.15	19
20	Administrator	2,319	2,319	80,272	34.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,142	18,018	271,845	15.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,785	1,938	23,522	12.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	247,864	269,194	$ 3,730,079 *	$ 13.86	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 1,837	5,1,3	35
36	Medical Director	Monthly	21,375	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,294	5,11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,506		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	17	$ 384	5,10,3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	17	$ 384		53

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Hurley	Administrator	0	$ 80,272
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,272

B. Administrative - Other

Description	Amount
Management Fee	$ 368,619
TOTAL (agree to Schedule V, line 17, col. 3)	$ 368,619
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
	Accounting Fees	$ 1,179
Various	Spec Consulting Fees	10,392
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 11,571

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 109,518
Unemployment Compensation Insurance	32,117
FICA Taxes	271,793
Employee Health Insurance	202,382
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	(6,946)
Payroll Overhead Allocated	1
401K / SMSP Match	26,192
Disability Payments	5,625
Employee Uniforms	567
Home Office Allocation	13,995
TOTAL (agree to Schedule V, line 22, col.8)	$ 655,244

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	66,324
Health Care Worker Background Check	
(Indicate # of checks performed 24)	489
Dues & Subscriptions	1,567
Association Dues	7,225
Advertising	19,963
Public Relations	2,221
Less: Non-Allowable Association Dues	(2,263)
Less: Public Relations Expense	(2,221)
Non-allowable advertising	(19,963)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 73,742

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,329
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,329

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS # 0020297 Report Period Beginning: 06/01/01 Ending: 05/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MANORCARE AT ROLLING MEADOWS **#** 0020297 **Report Period Beginning:** 06/01/01 **Ending:** 05/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 7225**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **56,906** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **84,864**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(1,035)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.